

‘Services First’

**An Assessment of Health and Wellness Centres
in Korba District, Chhattisgarh**

State Health Resource Centre, Chhattisgarh

2018

Introduction:

Comprehensive Primary Healthcare (CPHC) is necessary for achieving Universal Health Coverage aimed in SDGs. Our National Health Policy 2017 includes CPHC as a key intervention. CPHC is one of two key pillars of Ayushman Bharat, the flagship national health initiative launched in 2018.

Upgrading the Sub-Health-Centres (SHCs), each covering around 5000 population into Health and Wellness Centres (HWCs) providing and linking with comprehensive primary care has been articulated as the key strategy for CPHC, along with making some improvements in PHCs. It aims to provide a wide range of primary care services to the people, closer to where they live. Further it includes the ambition to build in continuity across levels of care and continuous care for chronic conditions.

The operationalisation is based on making available at sub-centre level, a Mid-level care provider who has requisite skills for primary level care. The strategy also includes improving infrastructure, availability of free drugs and access to free diagnostics along with greater community-participation and health-promotion.

The policy announcements have been backed by funding through the National Health Mission (NHM). A rollout plan was laid out by the Task force on CPHC in Ministry of Health and Family Welfare in year 2015, subsequent to which NHM has included it in its PIP based funding process.

So far, very limited experience is available on implementation of HWCs. Tamilnadu piloted implementing HWCs in year 2017 and its experience has been studied. Apart from Tamil Nadu, Chhattisgarh is a state with more than one year experience of implementing HWCs. It is important to look at how it was implemented in Chhattisgarh and what are the results and lessons from this experience. With this aim in mind, this assessment was taken up by the State Health Resource Centre, which is the additional technical capacity organization working for the Department of Health and Family Welfare in Chhattisgarh.

Korba district of Chhattisgarh was a pioneer in initiating Health and Wellness Centres (HWCs). The district initiated 70 HWCs in May 2017 at rural sub-centres across the five blocks of the district. This report presents the findings of an assessment carried out of HWCs in Korba district.

About Korba district: Korba is one amongst the districts identified as ‘Aspirational districts’ by Government of India. Korba town is well known for its Power Plants and Aluminium industry. Compared to the industrialized headquarters town, the rural part of the district is quite different. 63% of the district’s population is rural. 57% of the rural population belongs to the Scheduled Tribes. All five blocks of the district come under the Fifth Schedule of the Indian Constitution, signifying the predominant tribal population of the district. A large part

of the rural population lives in remote and forested areas with challenges of accessibility and communication.

Table 1: Demographic Profile of Korba district (2011)				
S.N.	Demographic Indicator	Population	SC population	ST population
1	Total population	1206640	124679	493559
2	Rural population	760350	67843	434129
3	Urban population	446290	56836	59430

*Source: Census 2011

The district has 719 villages. It has 9 urban areas (towns) with a total of 124 urban wards. The government health facilities include a district hospital, 4 CHCs, 38 PHCs, 4 Urban PHCs and 259 HSCs. This assessment study covers only the rural areas. The average population per sub-centre in 2011 was around 3000, reflecting the population-norm for HSCs in tribal areas.

Aim: The aim of the study is to assess the Health and Wellness Centres at Sub-centre level in Korba district in terms of achieving comprehensive primary healthcare in first year of their operation.

Objectives:

- a) To assess the increase in volume of ambulatory care (out-patient) caseload handled by sub-centres in a year of being converted into HWCs
- b) To assess the range of services provided by HWCs in Korba district
- c) To understand staff perceptions on benefits of HWC and difficulties involved
- d) To recommend measures for improving effective coverage through HWCs

Methodology and Sampling:

- a) **Quantitative Assessment:** This assessment is focused on the volume and variety of services provided by sub-centres. It looks at scenario in April 2017, just before the sub-centres became Health and Wellness Centres. Then it is compared with the situation a year later for April 2018.

The main data is the no. of patients cases attended to. The data was collected from Outpatient registers of sub-centres for one week each in April 2017 and April 2018. The presumptive diagnosis/symptoms for each patient attended were coded, entered in computers and analysed.

Sample: Out of the 70 rural HWCs at SHC level, 15 were selected randomly. The block-wise list of surveyed HWCs is given in Annexure -1. The average population of surveyed HSCs in 2017 was around 3300.

Estimation of need for primary ambulatory care: According to National Sample Survey Organisation, around 10% of the population has an ailment over 15 days. Thus, in a 3300 population of a sub-centre in Korba, around 155 episodes of illness are estimated, weekly. In addition, around 330 cases of chronic diseases are expected in a population of such size (around 10%). Assuming that a chronic patient will need to visit HWC average once a month, around 75 chronic disease cases should visit a HWC in a week. Thus ideally, we expect for a HSC with population of 3300, weekly 230 patients comprising 155 acute ailment cases and 75 visits of chronic disease patients.

- a) Case Study: In order to understand what goes into making of a successful HWC, one well-performing HWC was taken up as a Case Study.
- b) Qualitative interviews of Human resources at HWCs were carried out to understand their perspective on benefits of HWCs, challenges and required improvements.

Findings:

Question 1: Did the footfall increase in sub-centre when it became HWC?

Before the HSC became an HWC, the average OPD per week was 18. A year after the HSC became an HWC, the average OPD had increased to 88 patients per week. This represents a nearly 5 times increase in OPD from the situation before.

Is this amount of coverage enough? With OPD of around 88 patients per week, annually one HWC can cover around 4700 patients. This will be around 1.4 times the total population of the area. A general thumb rule says that an annual OPD rate of twice the population is excellent. Thus, HWCs in Korba seem to have achieved around 70% level of the excellent-benchmark in terms of total patients covered.

Thus, by covering 88 cases a week, HWCs were able to cater to 38% of the ambulatory care needs of the population, compared to just 8% earlier. Another way to assess the performance of HWCs in Korba is to compare with no. of OPD cases handled in Tamilnadu. In Tamilnadu, upgrading a HSC into a HWC had resulted in increasing its share in OPD care from 1% to 17%.

Combined with PHCs, this represents doubling the number of patients provided primary curative care services.



What was the spatial distribution of patients using HWC's services, within the area? An HWC on an average covers 3 villages in Korba. While half of the patients who came to the HWC were from the same village where it was situated, the rest 50% belonged to the two relatively distant villages. This average situation showed that there was further scope to attract patients from the villages situated at a relative distance from the HWC. Mobilisation by Mitanins (ASHAs) helped in most cases in this regard.

Where were such cases getting treatment earlier? According to the qualitative interviews with PRI members, ANMs and ASHAs, the bulk of this un-covered caseload was earlier going to unqualified private practitioners (quacks). The availability a functional HWC in the area cut down the local practice of such unqualified-practitioners to around half of earlier. Many of the quacks shifted their operations to villages not covered by HWCs.

Question 2: What was the range of services in HWCs? Did it expand when the HSCs were made HWCs?

The range of services provided by the HSCs before and after becoming HSCs is clear from the table below:

Table 2: Weekly- Condition wise Total OPD before & after:

Conditions	Total Weekly OPD-April 2017	Total Weekly OPD-April 2018
ANC	17	101
FEVER/MALARIA	39	138
COLD & COUGH	59	227
ACUTE RESPIRATORY INFECTION (ARI)	0	20
ACHES & PAINS	56	219
DIARRHOEA/ VOMITTING	43	95
CHICKEN POX	0	9
DEWORMING	6	4
SKIN INFECTIONS	13	81
RTI/UTI	1	5
TYPHOID	0	1
TUBERCULOSIS	0	6
LEPROSY	0	1
TRAUMA/FRACTURE	0	3
MINOR INJURY / BURNS	9	42
EAR INFECTION (ENT)	0	4
EYE CARE	2	10
DIABETES SCREENED CASES	2	13
DIABETES ON TREATMENT	0	18
HYPERTENSION SCREENED	1	51
HYPERTENSION ON TREATMENT	0	64
HYPERTENSION with DIABETES ON TREATMENT	0	3
ASTHMA/COPD Referred	0	1
ASTHMA/COPD ON TREATMENT	0	2
EPILEPSY ON TREATMENT	0	1
DOG BITE	0	1
DEFICIENCY ILLNESSES/ SEVERE MALNUTRITION	0	2
OTHERS	28	207
TOTAL	276	1327

The HWCs in Korba were able to provide a wide range of primary curative care services. HWCs were responsive in meeting the curative care needs of rural patients. Many of the chronic diseases got covered for the first time at a SHC level when their services were upgraded into HWCs. A big increase was observed in coverage of acute conditions.

Question 3: Were NCDs covered adequately in the HWCs?

Services for NCDs include 2 main components:

a) **Screening for NCDs:** Screening for diabetes and hypertension in these 15 sub-centres increased from 3 cases to 64 cases per week. This represents a twenty times increase.

Table 3: Status of Screening of Diabetes and Hypertension in weekly clinic:

Condition	Total Weekly OPD-April 2017	Total Weekly OPD-April 2018
Diabetes screened cases	2	13
Hypertension screened	1	51
Total	3	64

The above numbers reflect that weekly around 4 to 5 persons are getting screened for NCDs per HWC. This represents only the routine or opportunistic screening. In addition, drives were taken up by most centres to conduct population based screening. Such drives involved a much larger number screened. For example on World Diabetes Day in 2017, each HWC sub-centre screened an average of 140 persons for hypertension and diabetes. The screening for cancers was however quite limited. Qualitative interviews with Mid-level providers showed that they were not confident whether subsequent confirmation and curative services would be available for cancer-screened cases.

b) **Treatment for NCDs:** Earlier, there was no treatment given for NCD confirmed cases in HSCs. Due to biweekly clinics by Assistant Medical Officers (AMOs) in sub-centres upgraded as HWCs, this treatment became available.

Table 4: Treatment of Diabetes and Hypertension in HWC sub-centres:

Condition	Weekly 2017	OPD-April 2018
Diabetes treatment cases	0	18
Hypertension treatment cases	0	64
Total	0	82

On an average 5 to 6 confirmed NCD patients visited a HWC in a week. It was found that on an average, monthly 25 NCD patients take drugs regularly from an HWC. This represents less than 10% of the expected NCD caseload in the population.

This indicated that two more issues needed to be assessed –

a) How many cases out of the expected caseload of NCDs have been identified?

b) What proportion of the confirmed NCD cases were coming each month to HWC for drugs and follow-up?

It was found that an average HWC had identified around 60 confirmed cases of NCDs over the period of one year. The expected average case load of NCDs was around 400 in a HWC population of 3300. Thus HWCs in their first year had identified/listed around 15% of the expected NCD load. Some sub-centres like Bundeli in Pali block had tried to address this by dedicating separate weeks or fixed days for NCD and RCH services so that RCH and NCD patients could be attracted by publicizing assured services.

The more important question was to assess whether the NCD disease cases were getting continuous care that is needed in such diseases. Out of the average 60 confirmed NCD cases identified per HWC over the year, an average of 25 patients turned up regularly each month at the HWC in order to get their follow-up check-ups and drugs. This issue was explored in further detail in three HWCs. It was found that in a HWC, without active follow-up from HWC side, the proportion of NCD cases coming for regular monthly follow-up was around 33%, and with very active follow-up by HWCs and ASHAs, it increased to 70%. But the most crucial issue that emerged from the qualitative interviews was the availability of NCD drugs. Most of the HWCs had adequate quantity of NCD-drugs to cover around 30 to 40 cases monthly. In such situations, HWC teams did not have the confidence to call all the patients each month to take their drugs. This in turn also affected their motivation to detect more cases, when they were already having a shortage of drugs for existing cases. For improving follow-up, Patient Support Groups have been advocated as an intervention. Jan Swasthya Sahayog, an NGO in Chhattisgarh has demonstrated its great usefulness. In Government run HWCs, the AMOs when asked about this idea, were quick to realize that it could be useful. But, they felt that unless enough drugs are always available, the concept may not work. For NCDs, many centres waited for the NCD drugs to arrive, before they could call the NCD patients to come and take their drugs. Thus, the quantities of drugs for NCDs with HWCs need to be increased and be replenished without uncertainty.

Acceptability of Services of HWC: Another aspect to look at is the acceptability of services. The increase in footfall shows that along with being more accessible, the services of HWC also earned acceptability amongst its population. This was examined by looking at the gender profile of the patients.

Table 5: Gender Profile of Patients seen in 15 sub-centres, before and after becoming HWC:

Gender	Weekly OPD-April 2017	Weekly OPD-April 2018
Male	109	466
Female	167	861
Total	276	1327

The no. of male patients coming to HWC increased 4.3 times. They formed 35% of footfall in HWC. While women have been traditionally using services of sub-centre, having considerable number of male patients indicates its wider acceptability.

Origin of HWCs in Korba district: The initiative was born out of a local innovation. Although HWCs and CPHC have been part of the discussions at policy level in Delhi from 2014-15 onwards, its origin in Chhattisgarh was due to a local innovative initiative of a PHC.

In Kothari PHC in Kartala block of the district, the team consisted of an MO and two Assistant Medical Officers (AMOs). AMOs are the diploma-holder clinician cadre that Chhattisgarh has. This team noticed that the footfall in their PHC was limited. They tried to organize fixed-day services for ANC and diseases and they tried publicizing the services of their PHC, in order to attract more patients. It did not happen. They realized that patients from relatively distant villages under the PHC jurisdiction were not coming to the PHC. They decided to take their services closer to the people. One AMO started a weekly clinic in a sub-centre (named Jarve). They received tremendous response from local communities and soon the Jarve sub-centre had an OPD footfall of around 50 patients in each weekly clinic. This was in November 2015.

The above PHC's team discussed this innovation, about an year later, with the Chief Medical Health Officer (CMHO) Dr PS Sisodiya. He was quite enthused by the initiative and its results. His view was that the public health system had been losing out to unqualified quacks because the government healthcare services at the sub-centre were too limited in range to meet the needs of the people. He decided to replicate the innovation across 70 of the sub-centres in the district. He was supported by state-authorities in NHM and technical support agency State Health Resource Centre in developing the concept further. In May 2017, the district was able to start around 70 HWCs. In August 2017, the state received its first sanction in NHM PIP for 118 HWCs. The Korba model of HWCs was widely appreciated in the state and it was presented in a National Workshop at NHSRC in August, 2017. The state government decided to expand the initiative to 6 districts in October 2017. In 2018, the programme became a national priority and was inaugurated by Prime Minister in Bijapur district of Chhattisgarh. In 2018-19, HWCs were started in all 27 districts.

Caseload handled by Different Service Providers

The HWCs in Chhattisgarh had two kinds of service providers:

- a) Assistant Medical Officers: They have a three year diploma in modern medicine along with one year of internship in HSCs, PHCs and CHCs. This cadre is unique to Chhattisgarh. The state had formed a law in year 2001 and set up this course in order to meet the shortage of MBBS doctors in rural areas. The state produced around 1300 such clinicians, most of whom were recruited by the state government and placed in rural PHCs. Around 40% of them are women. They had experience of providing primary clinical services in PHCs for nearly a decade by year 2017. They were the natural choice for providing services in HWCs because their curriculum and role matched the Mid-level care provider conceptualized in CPHC. This cadre was a key advantage for Chhattisgarh in rolling out its HWC operations. Around 600 PHCs in the state have two AMOs. From such PHCs, one AMO is sent to a sub-centre level HWC twice a week to conduct biweekly out-patient clinics. All of them had earlier received a 10-day training at CMC Vellore, on primary care. When they joined HWC operations, they were provided additional trainings which also included one training-course designed and conducted by AIIMS, Raipur. This training was particularly tailored to strengthen their clinical skills for CPHC.

- b) ANMs and Male MPWs: The state has ANMs in most of its HSCs and 60% of them also have a male MPW posted. Around 30% of the existing 650 HWCs in the state

have a second ANM and the rest are in the process to recruit their second ANMs. The ANMs provide support to AMOs during biweekly clinics at HWCs. In addition, the ANMs conduct clinics for ante-natal cases and simple-acute illnesses on rest of the days. The HWCs studied in Korba had one ANM each and had biweekly clinics by AMOs, supplemented by another 2-3 days of clinics by ANMs in each centre.



The provider-wise break-up of cases seen by them is given below:

Table 6: Provider-wise break-up of out-patients handled in 15 sub-centres before and after HWC

Provider	Weekly OPD-April 2017	Weekly OPD-April 2018
AMO	0	658
ANM	276	669
Total	276	1327

Thus, ANMs contributed to around half of the total services provided by HWCs.

There was a variation across diseases (as expected) in the relative caseload handled by the two kinds of providers. Table below shows that while ANM was more focused on simple acute illnesses and AMOs focused on chronic and more complex cases.

Table 7: Condition wise Total OPD by ANM & AMO- before & after in weekly clinic:

CONDITION	April-18- Weekly OPD		April-17-Weekly OPD
	AMO	ANM	ANM
ANC	44	57	17
FEVER/MALARIA	79	59	39
COLD & COUGH	97	130	59
ARI/ PNEUMONIA	11	9	0
ACHES & PAINS	105	114	56
DIARRHOEA/ VOMITTING	39	56	43
CHICKEN POX	1	8	0
DEWORMING	3	1	6
SKIN INFECTIONS	39	42	13
RTI/STI	5	0	1
TYPHOID	1	0	0
TUBERCULOSIS	2	4	0
LEPROSY	1	0	0
TRAUMA/FRACTURE	1	2	0
MINOR INJURY / BURNS	23	19	9
ENT CASES	2	2	0
EYE CARE	7	3	2
DIABETES SCREENED	12	1	2
DIABETES ON TREATMENT	12	6	0
HYPERTENSION SCREENED	31	20	1
HYPERTENSION ON TREATMENT	35	29	0
HYPERTENSION & DIABETES ON TREATMENT	3	0	0
ASTHMA/COPD IDENTIFIED	0	1	0
ASTHMA/COPD ON TREATMENT	1	1	0
EPILEPSY ON TREATMENT	0	1	0
DOG BITE	1	0	0
CHILD IMMUNIZATION	0	3	5
DIFICIENCY ILLNESSES/ MALNUTRITION	0	2	0

OTHERS	107	100	28
TOTAL	658	669	276

In terms of acceptability of the two kinds of providers to Men and Women patients, the following table gives the picture:

Table 8: Provider-wise and Patient Gender-wise break-up of out-patients handled in 15 sub-centres before and after HWC

Provider	Weekly OPD-April 2017		Weekly OPD-April 2018	
	Male	Female	Male	Female
AMO	0	0	232	426
ANM	109	167	234	435
Total	109	167	466	861

Thus, for both kinds of providers, around one-third of the patients seen by them are male. Thus in HWCs, AMOs as well as ANMs seem to be acceptable to men as well as women patients.

A detailed Disease and Gender wise break-up of cases handled by the two kinds of service providers is given in Table 9.

Table 9: Gender wise condition profile in weekly clinic:

Conditions	April-18- Weekly OPD					April-17- Weekly OPD		
	AMO		ANM		Total	ANM		Total
	Female	Male	Female	Male		Female	Male	
ANC	44	0	57	0	101	17	0	17
FEVER/MALARIA	44	35	30	29	138	21	18	39
COLD & COUGH	65	32	74	56	227	40	19	59
ARI	6	5	6	3	20	0	0	0
ACHES & PAINS	69	36	80	34	219	30	26	56
DIARRHOEA/ VOMITTING	18	21	34	22	95	24	19	43
SKIN INFECTIONS	23	16	24	18	81	6	7	13
CHICKEN POX	1	0	2	6	9	0	0	0
DEWORMING	3	0	1	0	4	2	4	6
RTI/UTI	2	1	2	0	5	1	0	1
TYPHOID	0	1	0	0	1	0	0	0
TUBERCULOSIS	2	0	3	1	6	0	0	0
LEPROSY	0	1	0	0	1	0	0	0
TRAUMA/FRACTURE	0	1	0	2	3	0	0	0

MINOR INJURY / BURNS	10	13	8	11	42	1	8	9
EAR INFECTIONS	2	0	2	0	4	0	0	0
EYE CARE	5	2	3	0	10	1	1	2
DIABETES SCREENED CASES	10	2	1	0	13	1	1	2
DIABETES ON TREATMENT	6	6	4	2	18	0	0	0
HYPERTENSION SCREENED	27	4	12	8	51	0	1	1
HYPERTENSION ON TREATMENT	18	17	23	6	64	0	0	0
HYPERTENSION with DIABETES ON TREATMENT	0	3	0	0	3	0	0	0
ASTHMA/COPD Referred	0	0	1	0	1	0	0	0
ASTHMA/COPD ON TREATMENT	1	0	1	0	2	0	0	0
EPILEPSY ON TREATMENT	0	0	1	0	1	0	0	0
POISONING	0	0	0	0	0	0	0	0
DOG BITE	0	1	0	0	1	0	0	0
CHILD IMMUNIZATION	0	0	3	0	3	5	0	5
DIFICIENCY ILLNESSES/ MALNUTRITION	0	0	2	0	2	0	0	0
OTHERS	70	35	64	36	175	23	5	28
TOTAL	426	232	435	234	1327	167	109	276

Qualitative interviews with the providers showed that they were motivated to provide services to patients in HWCs. Their motivation was initiated by the ‘change management’ provided by the district health leadership. Getting the required drugs was a necessary condition for motivation which the district leadership was able to fulfill. Getting additional training, especially from AIIMS was a morale booster for AMOs. But, the factor which sustained their motivation was the community’s enthusiastic response and the ‘social recognition’. The team of AMOs and ANMs got a lot of support from Mitanins (ASHAs), in publicity of HWC’s services, in mobilization of patients, their follow-up and also in making the HWC a vibrant hub of activity in the village.

In NHM PIP 2018-19, HWCs were expanded across all 27 districts of the state. Around 600 HWCs were started in sub-centres by sending AMOs from PHCs to conduct biweekly clinics there, in addition to what ANMs could cover. The model helped in maintaining a strong link between the PHC and the HSC level HWC. Thus HWC did not end up being a stand-alone unit and instead had an organic linkage with the PHC. It helped in diagnostics and also in arranging drugs for HWC from PHC, when needed.

Case Study - The HWC at Dhelwadih

Dhelwadih sub-centre is among the best performing HWCs in Korba district. The following are the key points that emerged from interviews of providers in the centre:

“Earlier when no AMO used to visit sub-centre, on an average 10-15 patients used to come. Now AMO visits clinic so people ask for him and services, if there have been no AMO visiting sub centre then the scenario would have been the same as it was earlier. Now there are variety of diseases which are treated in the sub centre by us, earlier I used to get confined to delivery and treating some minor illnesses”, says the ANM posted in sub centre.

AMO posted in Dhelwadih perceives this intervention as treating patients in periphery (sub centre), closer to where people live, is important. “We have many AMOs in our district, in some PHCs there is 2-2 AMOs posted and results are evident, when we were deputed to sub centres twice in a week to cater health services, without affecting the functionality of PHC as there are MO/MO (AYUSH), staff nurse, ANM etc who are enough to manage the PHC case load in the absence of AMOs”.

The sense of mentorship by AMOs after getting placed at the sub centre has helped in gaining confidence in ANM and other staff while treating the patient. But yes convincing patients that they usually don't need injections remains a challenge.

In Dhelwadih an ophthalmic-assistant also comes once a month to provide eye-care services. And it is not that he is just confined to his work, working along with AMO & ANM he has enhanced his skills & is capable of doing other tasks also, like handling diagnostics etc which has helped other staff to manage and share the increased caseload.

“They tried to provide every possible service be it consultation, availability of AMO, regular supply of drugs, availability of diagnostic etc at sub centre level, which has increased trust in people and in turn increased the caseload.”

How people started coming to the HWC?

Earlier patient came along with Mitadin. Now patients come according to their need. Reason behind this is that now services are there, now a clinician is there, medicines are available; diagnostics is available under one roof. People don't have to run here and there in search of services, this is why they have started to come to the sub-centres. Earlier it was difficult to get the drugs & diagnostics but nowadays timely availability of drugs & diagnostics has strengthened this intervention.

Approach to Management of NCD cases:

After confirmation of any of the NCD cases they provide drug for the respective disease for 15 days. “In case of Non-communicable diseases they don't start any drug immediately, they counsel them on diet & exercise, call the patient for next visit to get the condition confirmed and if controlled, treatment is initiated with lower dose of drugs for 15 days and call them

after 15 days. If the drug does not respond well then the patient is referred to CHC because it is out of our level” says the AMO.

Approach to Referral:

Patients are referred to such centres where the facilities are available. They make sure that the patient is referred to the government institutions. It is tracked that the patient has reached the desired centre and their treatment is started. As told by the AMO, “patients of heart disease were identified here and referred to District hospital. We at HWC are in regular contact with the patients to monitor their well-being.” For proper follow up of identified NCD patient is taken care by ANM and ASHAs. A record of identified NCD patients who regularly require medication is maintained by the ANM and when ANM cannot catch a patient, ASHAs definitely find them and bring to HWC.

IEC:

This was initiated by Mitans (ASHAs). They spread awareness about HWC and its services by wall-writing and visited each and every house, identified the sick individuals in a household and brought them to the sub centre. “They used to bring patients daily on an average they used to bring 4-5 patients daily. Sometimes OPD crossed 60-70 patients in a day”.

Drugs and Diagnostics:

Availability of drugs played a vital role in this intervention. Earlier drugs like anti-hypertensives, anti-diabetics, skin infections, ENT and sometimes even anti-malarials were missing. Services other than ANC were not consistent. Also due to lack of diagnostics supply (in case of diagnostics) services treatment was not possible. But with due course of time diagnostics like glucometer strips became available which made screening of diabetes possible.

Training & skills:

“Refresher course for AMO played a vital role in this intervention as in particular when it comes to NCD management various aspects like when to start treatment, how to manage, when to refer patient were given more emphasis and this helped them to treat & manage patient on field”, says AMO posted in Dhelwadih.

“After working along with sir I have learnt a lot, it has enhanced my knowledge & skills. Now I feel more confident while treating the patient.” said ANM about mentoring she received from the AMO during the work.

Key Lessons:

The emergence of Health and Wellness Centers in Chhattisgarh was a result of local practical innovation developing alongside significant policy initiatives from government. It started as a response to the realization that primary healthcare needs should be addressed by the public health system and it can be done if a required range of services can be provided to people close to where they live. Distance matters a lot in accessing healthcare. The study of HWCs in Tamilnadu had also shown that such provision of services at low distances to people can reduce the out of pocket expenditure drastically.

The sub-centres were the closest health facility to the people but also an under-utilised unit in the health system. In Chhattisgarh's case, the sub-centres could be functionalised as HWCs by using the spare HR capacity available in form of two AMOs per PHC. Having the AMO cadre facilitated faster roll-out of HWCs in Chhattisgarh but the principle remains that skills for primary care need to be made available at sub-centre level and having local providers in the role is useful. Sub-centres were able to attract patients which better-equipped PHCs could not. Role of Mitanins (ASHAs) is important in getting the patients to HWC in the initial phase. Once the services of HWC are being accessed by enough people, role of ASHA can shift to ensure follow-up, especially of chronic disease cases.

Results of the assessment show that HWCs provided 'Patient-centric' services, responsive to their needs. Instead of being driven by a vertical agenda, this patient-centredness was the most important element in its conceptualisation. When people fall sick, they want curative services. The clarity of will and the ability to provide the requisite range of services at the sub-centre was the key to its success. If the HWCs were focusing on a narrow activity, say NCD screening mainly, the success would have remained elusive.

Being responsive to community-needs generated the social recognition for the providers and that in turn, built their motivation. The role of district health leadership in creating the required staff motivation around the initiative was important for 'change management'. The concept of the 'Primary Care Team' including Mid level provider (AMO), ANMs/male MPWs and ASHAs (Mitanins) is crucial too. It makes it inclusive and links HWC strongly to community, through ASHAs. Unlike other health facilities, sub-centres are situated within village communities and when they provided responsive services to local community, they

became a beehive of activity and closer to being 'community-owned'. The interest shown by the PRIs in the HWCs was too an indication of that.



In terms of implementation, along with the clarity on providing requisite range of services and the skilled HR to do so, the other most important factor determining success or failure of HWCs was the availability of drugs. Their range should match the range of services we want to provide, their quantity should be adequate for the caseload and there should be a sense of certainty of timely replenishment. This was important for building and sustaining the confidence of patients as well as providers in HWC. For chronic diseases, continuity of care and regular follow-up and medication depended heavily on the availability of drugs.

The continuity of care across levels of care, i.e. between HWC and referral institutions, still remains an unsolved challenge. It works to some extent in HWCs like Dhelwadih due to exceptionally motivated providers but a system to ensure it across HWCs is yet to emerge.

To conclude, the HWCs initiated in Chhattisgarh's Korba district indicate the substantial gains that the concept offers when implemented on ground. It provided a wide range of services and was able to cater to a large proportion of the primary curative care needs in rural population. The overall primary care coverage increased substantially due to HWCs. It was able to start providing care for chronic diseases but needs further improvements in supply of drugs to extend its success further.